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Beyond Medicare for All: An Anarchist Alternative to Government Health Care

by Sarah Miller

When I first met Mary, she had been admitted to the hospital for the fifth time in six months. Mary was a sixty-seven-year-old woman, a former smoker with chronic lung issues. The nurses joked, “Oh, I guess it’s your turn to deal with her.” She had come to the Emergency Department again the previous night at 9:00 p.m. because she felt like she couldn’t breathe. In a panic, she called 911.

As I started my assessment, I asked her about her frequent visits. “Hi, Mary! I’m going to be your nurse this evening. So what happened? I saw that you scheduled an appointment with your lung doctor 2 weeks ago?” Yes, she assured me, she did see her doctor. He started her on a new inhaler and gave her samples to try. She felt like the new medication was helping, but when she went to pick up the prescription at the pharmacy, the cost was almost $300 for a one-month supply. So she went back to her old medications and her lung issues got worse once again.

Mary’s daughter helped her apply for a patient assistance program through the drug manufacturer, but she was still waiting for a response. Medicare started when she was sixty-five years old, but it did not cover medications unless she enrolled in Part D. Part D is generally managed by private insurance companies like the American Association of Retired Persons (AARP) or Aetna and entails a separate policy with associated premiums, deductibles and co-pays.

For Further Reading:

Self-Organized Health Structure of Exarchia (ADYE): https://en.squat.net/tag/k-vox/

Bayou Action Street Health (BASH):
https://www.facebook.com/BayouActionStreetHealth/

Common Ground Relief: scott crow, Black Flags and Windmills: Hope, Anarchy, and the Common Ground Collective (Oakland, CA: PM Press, 2014).https://www.pmpress.org/index.php?l=product_detail&p=618

Prevention Point Philadelphia: https://ppponline.org

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This essay is from Perspectives on Anarchist Theory‘s “Beyond the Crisis” issue, available here from AK Press:
https://www.akpress.org/perspectivesonanarchisttheorymagazine.html

Notes:

1. J. Rau, “Medicare fines 2,610 hospitals in third round of readmission penalties.” The Inquirer, October 3, 2014. Available at http://www.philly.com/philly/health/healthcare-exchange/Medicare_fines_2610_hospitals_in_third_round_of_readmission_penalties.html.

2. J. George, “St. Joseph’s Hospital closing tied to reduction in state financial support.” Philadelphia Business Journal, December 30, 2015..

3. Medicare.gov, “Costs at a glance.” 2018. Available at https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.
4. R. Siegel, and C. Columbus, “As Cost Of US Health Care Skyrockets, So Does Pay Of Health Care CEOs.” National Public Radio, July 26, 2017. Available at https://www.npr.org/sections/health-shots/2017/07/26/539518682/as-cost-of-u-s-health-care-skyrockets-so-does-pay-of-health-care-ceos.

(Cover art by Amanda Priebe https://www.amandapriebe.com)
(HC4A art by Josh MacPhee http://justseeds.org)

revolutionary change happens.

As a primary goal, Medicare for All is reformist and not revolutionary. Universal health care is a temporary solution under the current capitalist health care system, but anarchists can reach for a genuinely socialized system based on self-management and cooperation. We know what kind of health care services our communities need. When we have doctors, nurses and other practitioners working together in a decentralized environment, providing care directly to patients without worry of insurance co-pays, this is where we build power. And no one can take that away.

waxes and wanes, causing periods of significant fluid retention and resulting shortness of breath. To make matters more complicated, Rodney lived alone and had chronic mental health issues. He did not always make it to his appointments and used the ER when he started to feel poorly.

He came to the ER three days after his most recent hospital stay, saying that he felt short of breath. His symptoms were worsening but the doctor advised that Medicare might not pay for another admission as he had just been discharged less than a week ago. He chose to return home, and promised to call his doctor in the morning. When the ambulance crew brought Rodney back to the ER two days later, he was intubated, unable to breathe on his own.

Medicare Will Never Be "For All"

"Medicare for All" is a rallying cry for much of the American Left, but why? Why do we seek out a government-based solution when Medicare has already failed so many? Ethically speaking, a system that provides for more people with fewer obstacles to receiving care is worth supporting. However, the reforms being proposed are still steeped in the status quo of the current capitalist health care system.

Universal health care proposes socialization of consumption, but not of the production or provision of medical services and care. While it may allow some people to have access to free health care, it does nothing to eliminate the fact that insurance companies and

directing care. By threatening hospitals and providers with decreased reimbursement for certain conditions, Medicare uses its power and influence to tell doctors how to treat their patients, what tests to run, which drugs to prescribe, and whom to admit to the hospital.

Medicare's reimbursement reduction programs, aimed at lowering the number of cases like Rodney's, exist to save money, not to help patients. In 2014, Medicare fined 77 percent of hospitals that serve lower-income patients–often called "safety-net hospitals"–for readmissions, compared to 36 percent of hospitals serving wealthier populations. (1) While researchers and medical professionals recognize that lower-income patients have limited resources for health maintenance, the penalties remain the same. Decreased Medicare reimbursement directly contributed to the closure of twenty-one US hospitals in 2016, including St Joseph's hospital in North Philadelphia, a 135-bed facility that served one of the poorest sections of the city. (2)

Even if someone is eligible for coverage, Medicare isn't free. If recipients earn less than $85,000 a year, their monthly premiums are $134. Add this to the 20 percent co-pay for services, plus out-of-pocket costs for medications. With certain Medicare Part D prescription plans, Medicare will not pay for prescriptions until a $400 deductible is met. Once the plan has paid $3,700 for medications, individuals' payments increase. As with most fees in our capitalist health care system, costs are only rising annually. (3)

need" approach to medical payments. While they are a religious order and not Marxist, they are collectivist and care for each other. Individuals and families contribute to a liability insurance fund based on assets and income. This fund, combined with contributions from the church, proceeds from fundraisers, and discounts negotiated with local providers, pays for the entirety of community members' hospital bills.

In other areas of the country, five states offer health insurance cooperatives using the same mutual aid strategies. Co-ops suffered a blow under the Obama administration when the federal government withheld previously promised funding for smaller insurance companies, including co-ops, under the Risk Corridor Program. In other cases of "too big to fail," the government issued subsidies to larger companies to keep them afloat. The Trump administration has also threatened to cut funding for health insurance co-ops. Government subsidies pump millions of dollars into insurance companies that in turn funnel millions to candidates in exchange for favorable legislation and policies. For-profit insurance will never work to benefit the consumer; therefore the best response is nonparticipation.

Lastly, and perhaps most importantly, is our need to build anarchist networks to create a viable health care system. Any alternative to the current health care system is going to start slowly and locally. One clinic in Philadelphia may inspire another in Pittsburgh. They share ideas on what works with interested anarchists in Cleveland, who then talk with an anarchist nurse they know in San Francisco. This is how

an increase in trained and licensed leftist physicians, nurses, pharmacists, paramedics, mental health professionals, and alternative medicine practitioners so this direct work can continue beyond disaster relief and gain credibility. As more anarchists enter the health care field, they will be able to shape institutional policies, organize workers to demand better patient care and working conditions, and build and adequately staff new mutual aid programs.

Current anarchist health care workers can encourage an increase in radical professionals by mentoring and teaching students and those interested in medical work. Those with training can provide street medic training and free first aid classes for underserved communities. There is also a need for a revolutionary faction in current unions and creation of new, nonhierarchical patient and worker unions.

Secondly, we need money to pay for services and supplies. This is unfortunately an all too common reality in the capitalist system. As health care services for the working class are increasingly underfunded or eliminated, we can no longer assume that Medicaid and Medicare will always be available. The push for privatization will likely cause for-profit health insurance companies to become the only option for most Americans. However, people can give funds directly for care instead of to insurance companies who siphon it directly into their profits.

Here in Lancaster County, Pennsylvania, the Amish practice a "from each according to ability and to each according to need"es contribute to a liability insurance fund based on assets and income. This fund, combined with contributions from the church, proceeds from fundraisers, and discounts negotiated with local providers, pays for the entirety of community members' hospital bills.

Bernie Sanders' ninety-six-page Medicare for All bill (S. 1804) is purposefully vague. He asserts that patients will have no co-pays, premiums or deductibles, yet gives no details of what will be paid for. He speaks of a formulary of medications to be covered by the program, but no mention of restrictions on what pharmaceutical companies can charge, and no limits on lobbying by drug companies. It is no surprise that Sanders' bill is supported by recipients of pharmaceutical company donations like Democratic New Jersey Senator Cory Booker. Even if it would become law, eighteen to thirty-five year olds would start receiving coverage four years after universal Medicare is implemented, much too late for people who need help right now.

Yet Sanders said that he does not expect this bill to pass. The proposal he is making to adequately and completely cover all Americans is not allowed under our current political system. There is too much at stake. Private insurance companies, drug manufacturers, medical equipment suppliers, and those receiving money from these groups do not want the system to change. It's simply too profitable. If lawmakers cannot accept an increase in Medicare and Medicaid coverage, there is no chance for a radical change through legislative channels.

Revolution, Not Reforms

Reforms are never permanent and are never an end goal. As we saw with attempts to dismantle the Affordable Care Act (ACA), any move toward helping the general population can be reversed at the whims of those in power. The United States imagines itself a democracy but nothing could be farther from the truth. Those in power are not concerned with the popularity of programs and reforms, and instead serve only their own interests. Only 25 to 35 percent of voters supported President Trump's GOP tax reform bill, yet senators and representatives pushed it through because it serves the needs of the wealthy. They are listening to their benefactors and not their constituents. The state does not have the interests of the working class in mind and never has, yet progressives continue to look to government to provide basic needs.

The state has never been in favor of affordable medical treatment. Historically, US leaders pushed against universal health care in favor of employer-sponsored insurance. In 1942, President Franklin D. Roosevelt imposed a freeze on wages called the Stabilization Act. In response, unions acted to advocate for workers. They started negotiating benefits and pensions, including health insurance, in order to provide laborers with something to replace lost income. At that time, private insurance was part of the employee benefit package and did not include co-pays and premiums.

Six years later, in 1949, President Harry S. Truman's proposal of universal health care was met with fears that it would lead the

unencumbered by insurance company formularies and co-pays. Clinics receive donated, unexpired medicines, and they then match available medications to patients in need. Prescriptions are required, but there are no insurance authorizations and no money changes hands. Free clinics and Direct Patient Care, a throwback to old style physician-patient relationships, also aim to treat patients without involving insurance.

Building a System: Next Steps

Health care without the state and corporate insurance can happen, but implementation necessitates small steps. It requires evidence of success to take away the fear of abandoning a system of health care delivery that's been in place for over seventy years. As people realize they can receive quality and affordable health care without worrying about swinging pendulums of reform, and without the undue influence and persistent failures of federal and private insurance companies, the state loses legitimacy and the working class gains power. medicationsClinics receive donated, unexpired medicines, and they then match available medications to patients in need. Prescriptions are required, but there are no insurance authorizations and no money changes hands. Free clinics and Direct Patient Care, a throwback to old style physician-patient relationships, also aim to treat patients without involving insurance.

We first need the resources to build systems that work. As natural disasters inevitably increase, there will be an ongoing need for relief workers at the ready to provide care. We require

Judgment and scapegoating are also factors in the lack of affordable care for substance abuse. Last October, after years of increased opioid addiction and overdose, Donald Trump declared the national opioid crisis a “Health Emergency”; but instead of providing funding for care, he placed blame on addicts while offering hollow gestures akin to the grossly ineffective “Just Say No” campaign of the 1980s. To fill in gaps left by the government and other nonprofits, Prevention Point in Philadelphia has been on the front lines of harm reduction for twenty-five years, providing syringe exchange, HIV testing and counseling, wound care, legal services, overdose reversal training, and detox and rehabilitation referrals.

The Mayor and Board of Health authorized their efforts, and they negotiated agreements with local law enforcement to prevent the arrest of heroin users. Their work, provided free of charge, is invaluable. A recent report showed that out of the high-risk groups susceptible to HIV infection, the IV drug using population was the only group to have a drop in infection rates, from 23 percent in 2004 to 10 percent in 2010. Newly elected Philadelphia District Attorney and civil rights lawyer Larry Krasner said he is in support of safe injection sites in the city, which Prevention Point has advocated for.

Resources and funding are always an issue when providing care outside of the traditional health care system. Organizations can accept donations like food, water, bandages and scanning equipment without restriction, but medications and needles are closely regulated by the FDA and local law enforcement. Safety-net pharmacies are filling the need for free medications medicationsClinics receive donated, unexpired medicines, and they then match available medications to patients in need. Prescriptions are required, but there are no insurance authorizations and no money changes hands. Free clinics and Direct Patient Care, a throwback to old style physician-patient relationships, also aim to treat patients without involving insurance.

country to communism. What happened was that health insurance was turned into a profit-heavy capitalist system. Almost seventy years after Truman rejected universal coverage, the highest salary for a health insurance CEO is $22 million a year. (4)

It makes sense that people want to stop inflated health care costs and obscene salaries, but reforms do nothing to change the core systems. When President Obama enacted the ACA in 2010, it did not reduce the power insurance companies have over consumers. The government required companies to take on enrollees who spent the most on health care–the elderly, chronically ill, and people with preexisting conditions. They did, but passed on that cost by raising premiums. In turn, people who could not afford the monthly costs were back to being uninsured or struggling to pay.

The largest benefit gained from the ACA was the expansion of Medicaid. Over sixteen million people became covered for the first time, allowing them access to preventative and routine health care as well as mental health and substance abuse treatment. In Pennsylvania, over 124,000 people struggling with drug and alcohol addiction entered Medicaid-paid detox and rehabilitation for the first time. Enter Paul Ryan, who, after the approval of the GOP tax bill, said that Medicaid and Medicare were “entitlement programs” and announced the Republicans’ plan to cut spending on both programs in 2018.

This is the natural progression for a government that has already cut funding to the Children’s Health Insurance Programmillions of children with parents who are low-income but do not qualify for Medicaid. Both Democrats and Republicans showed that they do not need popular support to pass bills and cut programs. They simply decide what poor people deserve.

Program (CHIP), which provides healthcare to millions of children with parents who are low-income but do not qualify for Medicaid. Both Democrats and Republicans showed that they do not need popular support to pass bills and cut programs. They simply decide what poor people deserve.

Another Health Care System Is Possible

As people begin to realize that the health care, pharmaceutical, and private and government industries are not serving them, groups are working independently without the support or resources of the state to give care where it is needed. For them, there is no lobbying for the next health care plan or waiting for bills to pass. There is just direct action and building dual power–the concept that communities are served by and responsible to themselves. There is no hierarchy and no reliance on the state for grants and oversight.

As with many dual power organizations, we see more forming outside of the US. Some, like the Self-Organized Health Structure of Exarchia (ADYE) in Greece, were born out of the economic crisis and growing illegitimacy of the government. Within the largely leftist Athens neighborhood of Exarchia, a community grew as an anarchist hub for those who wished to resist oppression by police, and increasingly from fascist groups.

The ADYE operates solely through volunteer caregivers and donations of money and supplies. Staffed by physicians, radiologists, therapists, dentists and nurses among others

ADYE serves anyone in need. The goal is a completely self-run, egalitarian health service to provide basic care to those who need it, regardless of ability to pay. They refer more complicated cases to local hospitals, but the ASYE provides care for general ailments and preventative healthcare.

In the US, Hurricanes Katrina and Harvey sparked health care mutual aid out of necessity and the desire to help when the government and NGOs were not meeting needs. Common Ground Relief, an anarchist collective touting the motto “Solidarity not Charity,” started in a mosque and on the streets of New Orleans in the aftermath of Hurricane Katrina. Following the closure of Charity Hospital, Common Ground’s clinic provided traditional and alternative health care to over sixty thousand people.

Similarly, medics with Bayou Action Street Health (BASH) took to the streets of Houston after the hurricane, reaching people who were still waiting for NGO relief. They transported residents for medical care and staged pop-up clinics throughout the city. Several mutual aid groups continue their disaster relief work through loose networks in Puerto Rico, Mexico, California, and Texas. They are often the only groups who show up to help in poor and underserved areas. After the emergency work is finished, mutual aid groups are staying in the communities to provide health care, long after the Red Cross and other relief groups have left. Recipients of mutual aid and street medic care often say that they build trust through their on-the-ground presence and nonjudgment.